



# **Essential Diabetes Mellitus Care Guidelines**

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**Wisconsin Diabetes Advisory  
Group  
2001**

# Why Diabetes?

## Huge public health problem

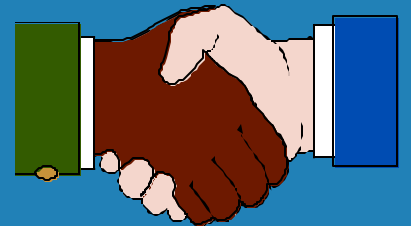
- serious
- common
- costly
  - controllable

# Diabetes Control Program

- Surveillance
- Health systems
- Community Interventions
- Health communication
- Coordination

# Wisconsin Diabetes Advisory Group

- Statewide, grass-roots approach
- Broad-based, diverse composition
- >55 key organizations
- Heart of the Diabetes Control Program (DCP)
- Goal is collaboration
- Provide guidance & expertise to the DCP



# Why Guidelines

- ⦿ Widespread variation
- ⦿ Need for improvement
- ⦿ Rapidly changing health care environment
- ⦿ Growing interest in quality
- ⦿ Growing public & employer demand
- ⦿ Growing use of locally developed guidelines
- ⦿ Provides standardization & consistency
- ⦿ Potential to impact large numbers

# Essential Diabetes Mellitus Care Guidelines

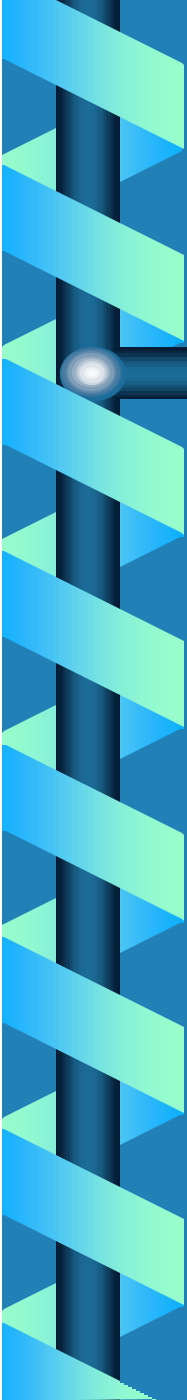
- Population-based
- Evidence-based
- Focus on preventive care
- Promote team care
- Partnership with patient
- Target provider, system, patient

# Components

- One page guideline
  - professional version
  - patient version (wallet card)
- Key Areas
  - concerns
  - care/test
  - frequency
- Supporting documents
  - evidence/references

# Implementation Tools

- Flow sheets
- Audit tool
- Oral health screening tool
- Foot screening tool
- BMI chart
- FAQ
- Personal diabetes care records
- Quality Improvement Guidelines



# ESSENTIAL DIABETES MELLITUS CARE GUIDELINES

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*Revised 2001 - by the Wisconsin Diabetes Advisory Group*

**Care is a partnership between the  
patient, family and the diabetes team**

# General Recommendations

## ⊗ Diabetes focused visit

- Type 1 - **every 3 months**
- Type 2 - **every 3-6 months**

(or more often based on control and complications)

## ⊗ Review management plan, problems and goals

each focused visit; revise as needed

- Assess physical activity/diet/weight-BMI/growth

# Glycemic Control

- **Review meds & frequency of low blood sugar** - each focused visit
- **Self blood glucose monitoring**, set & review goals - 2-4 times/day or as recommended
- **HbA<sub>1c</sub>** (goal: <7.0% or ≤ 1% above lab norms) - every 3-6 months: (if > 8.0%, action is recommended)

# Kidney Function

- **Urine for microalbumin** (if higher than 30mcg/mg creatinine or >30mg/24hr, initiate ACE inhibitor, unless contraindicated)
  - type 1 - begin at puberty or after 5 year duration, then yearly
  - type 2 - at diagnosis, then yearly
- **Creatinine clearance and protein** - yearly, after microalbuminuria > 300mg/24 hours
- **Urinalysis** - at diagnosis & as indicated

# Cardiovascular

- **Smoking** - assess, counsel, refer
- **Lipid profile** - Children: if >2 yr., after diagnosis & once glycemic control is established; repeat yearly if abnormal.  
Adults: yearly.

If abnormal follow **NCEP** guidelines.

## **Adult goals:**

Triglycerides <200 mg/dL

HDL >45 mg/dL

LDL <100 mg/dL (optimal goal)

# Cardiovascular (cont.)

- **Blood pressure** - each focused visit

Adult: **<130/80**    125/75 if diabetic nephropathy)

Child: below 90% of ideal for age

- **Aspirin prophylaxis** - > age 40 years (unless contraindicated)

# Eye Care

- Dilated eye exam by ophthalmologist or optometrist
  - type 1 - within 3-5 years of onset or age 10 years, whichever occurs later, then yearly
  - type 2 - at diagnosis, then yearly (or in alternate years at discretion of the ophthalmologist/optometrist)
    - must meet all following criteria:
      - HbA1c within 1% of normal
      - BP at or below 130/80
      - dilated eye exam in previous year ® no retinopathy

# Oral Health Care

## • Oral health screening

- by health care provider each focused visit
- if dentate, refer for dental exam every 6 months (every 12 months if edentate)

# Foot Care

- **Inspect feet with shoes and socks off -**  
each focused visit, stress need for daily self-exam
- **Comprehensive lower extremity exam -**  
yearly
  - including mono-filament test

# Pregnancy

- ⦿ **Assess contraception/discuss family planning/assess medications for teratogenicity** - at diagnosis & yearly during childbearing years
- ⦿ **Preconception consult** - 3-4 months prior to conception (some medications are contraindicated during pregnancy)

# Self-Management Training

- **By diabetes educator, preferably a CDE** - at diagnosis, then every 6 - 12 months or more as indicated by patient's status
- **Curriculum** to include the 10 key areas of the national standards for diabetes self-management education

# Nutrition Therapy

- By a dietitian, preferably a CDE -
- at diagnosis, then:
  - type 1 - <18 yr., every 3-6 months  
              >18 yr., every 6-12 months
  - type 2 - every 6-12 months  
(or more often if indicated by the patient's status)
- To include areas defined by the American Dietetic Association's Nutrition Practice Guidelines

# Immunizations

- **Influenza vaccine** - per Advisory Committee on Immunization Practices (ACIP)
  - yearly
- **Pneumococcal vaccine** -per ACIP
  - usually once

# Diabetes Control Program

- 608-261-6855 - to order materials
- 608-261-6871 - Questions
- Diabetes Resource Guide
- Guidelines, wallet cards, tools
- <http://www.dhfs.state.wi.us/health/diabetes/index.HTM>